STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

and

[MANAGED CARE ORGANIZATION]

AMENDMENT NO. 5 TO THE CONTRACT FOR FURNISHING HEALTH SERVICES BY A MANAGED CARE ORGANIZATION 2018-24-XXX-KA5

WHEREAS, the Parties to the Contract for Furnishing Health Services by a Managed Care Organization ("Contract"), the **Illinois Department of Healthcare and Family Services**, 201 South Grand Avenue East, Springfield, Illinois 62763-0001 ("Department"), acting by and through its Director, and **[Managed Care Organization]** ("Contractor"), desire to amend the Contract; and

WHEREAS, pursuant to Section 9.1.18, the Contract may be modified or amended by the mutual consent of the Parties; and

WHEREAS, the Contract has been previously amended;

NOW THEREFORE, the Parties agree to amend the Contract further as follows:

1. Article I is amended by deleting and replacing subsection 1.1.74 as follows:

   1.1.74 **Enrollee** means a Participant who is enrolled in a MCO. "Enrollee" shall include the guardian where the Enrollee is a minor child or an adult for whom a guardian has been named, provided that Contractor is not obligated to cover services for any individual who is not enrolled as an Enrollee with Contractor.

2. Subsection 2.3.2.3 is deleted in its entirety and replaced with the following:

   2.3.2.3 A liaison who will be a consumer advocate for High-Needs and Special Needs Children. This individual shall be responsible for internal advocacy for these Enrollees' interests, including ensuring input in policy development, planning, decision-making, and oversight.

3. Subsection 4.10.3.2.5 is deleted in its entirety and replaced with the following:

   4.10.3.2.5 other reasons, including: poor quality of care; a sanction imposed by the Department pursuant to 42 CFR 438.702(a)(4); lack of access to Covered Services; lack of access to Providers experienced in dealing with the Enrollee's healthcare needs; or if the Enrollee is automatically re-enrolled pursuant to section 4.11 and such loss of coverage causes the Enrollee to

miss the open Enrollment Period; or an Enrollee's Primary Care Provider's contract with Contractor is terminated resulting in disruption to the Enrollee.

4. Subsection 4.16.1.7 is deleted in its entirety and replaced with the following:

4.16.1.7 the name and phone number of the Enrollee's PCP (do not include for Dual-Eligible Enrollees).

5. Subsection 4.16.2 is deleted in its entirety and replaced with the following, and is further amended by adding new subsection 4.16.2.1:

4.16.2 Contractor shall send the identification cards to the Enrollee no later than five (5) Business Days after receipt of the monthly 834 Audit File.

4.16.2.1 For Dual-Eligible Enrollees whose enrollments are received by Contractor after receipt of the monthly 834 Audit File, Contractor shall send the identification card no later than five (5) Business Days after receipt of the 834 Daily File.

6. Subsection 5.3.2, and all of its subsections, are deleted in their entirety and replaced with the following:

5.3.2 Pharmacy Formulary and Preferred Drug List (PDL) Effective January 1, 2020.

5.3.2.1 **Federal Medicaid drug rebate program.** Contractor shall cover only drugs made by manufacturers who participate in the federal Medicaid drug rebate program. This requirement applies to both prescription and over-the-counter drugs. This requirement does not apply to non-drug items, such as glucose monitoring supplies, as those products are not drugs and are not eligible for the federal Medicaid drug rebate program. The Department will routinely provide Contractor an updated report of manufacturers that participate in the federal Medicaid drug rebate program.

5.3.2.2 **Covered outpatient drugs**. Contractor shall provide coverage of covered outpatient drugs as defined in Section 1927(k)(2) of the Social Security Act. Non-preferred drugs meet the definition of a covered outpatient drug and cannot be excluded from coverage. In the event a covered outpatient drug is not covered through Contractor's pharmacy benefit, it must be covered through Contractor's medical benefit. In the event Contractor does not include a covered outpatient drug on its pharmacy formulary, Contractor must have a process for Enrollees to access that drug through a prior authorization process, in accordance with 42 CFR §438.3(s)(1).

5.3.2.3 **Compliance with preferred and non-preferred products**.

5.3.2.3.1 Contractor shall cover as a preferred product all products listed as preferred on the Department's weekly Preferred Drug List (PDL) NDC file.

5.3.2.3.2 Contractor shall cover as a non-preferred product all products listed as non-preferred on the Department's weekly PDL NDC file.

5.3.2.3.3 Contractor shall not disadvantage any preferred product to another preferred or non-preferred product in the same drug class on the Department's PDL.

5.3.2.3.4 Where the Department lists a brand name product as preferred, and its generic equivalent as non-preferred, Contractor must also list and treat the brand name product as preferred and the generic drug as non-preferred.

5.3.2.4 **Prior authorization status**. Contractor shall not require prior authorization for any preferred drug for which the Department does not require prior authorization. Contractor may request authorization from the Department to require a clinical prior authorization on all preferred drugs in a class, where HFS does not require prior authorization for that class, and the Contractor may require a clinical prior authorization only if approved in advance by the Department. In those classes where the Department requires a clinical prior authorization for all preferred drugs in the class, products are listed as "Preferred Requires Prior Authorization" on the Department's PDL. Contractor may allow, without a prior authorization requirement, products that are listed on the Department's PDL as "Preferred Requires Prior Authorization." If Contractor does so, Contractor must make all preferred products available without a requirement for prior authorization in that class. Contractor may determine its own clinical prior authorization criteria unless otherwise stipulated by the Department.

5.3.2.5 **Requirement to use preferred products**. Contractor shall require Enrollees to use preferred products unless there is a clinical reason the Enrollee must use a non-preferred product.

5.3.2.5.1 *Age limits*. Contractor shall be no more restrictive than the Department in regard to age limitations for PDL products.

5.3.2.5.2 *Days' supply*. Contractor shall be no more restrictive than the Department in regard to days' supply allowed for PDL products.

5.3.2.6 **Rebates for drugs and other products on the PDL**. Contractor, including Contractor's Pharmacy Benefit Manager (PBM) or its Subcontractors, is prohibited from negotiating any rebates with manufacturers for drugs or other products listed on the Department's PDL. In the event Contractor, its PBM or other Subcontractors have an existing rebate agreement with a manufacturer, all products listed on the Department's PDL must be exempt from such rebate agreements.

5.3.2.7 Unless otherwise prohibited in this contract, Contractor may establish clinically appropriate utilization controls, such as quantity and dose limits. Contractor shall utilize the Department's step therapy and prior authorization requirements for family-planning drugs and devices pursuant to the Department's PDL and Attachment XXI.

5.3.2.8 **PDL file**. The Department will provide Contractor a PDL file. Contractor shall provide the PDL file to their Pharmacy Benefit Manager (PBM) within two (2) Business Days of receipt.

5.3.2.8.1 *PDL file format and frequency*. The Department will provide Contractor, on a weekly basis, the PDL file at a National Drug Code (NDC) level. The PDL file will be a full file containing all NDCs included on the Department's PDL and include age limitations, days' supply allowances, and drug class. Contractor shall load the file within seven (7) Business Days of receipt of the file.

5.3.2.8.2 *Negative formulary changes*. The Department will provide Contractor with negative formulary changes at least forty-five (45) days prior to the effective date of the change. Contractor shall make all system and programming changes necessary to implement the change on the effective date.

5.3.2.8.3 *New NDCs*. When Contractor loads new NDCs for products that are listed on the Department's PDL, Contractor shall code the product's preferred or non-preferred status the same as other drugs that are the same drug, dosage form, strength, and route of administration. When the drug is multi-source, and the brand/innovator product and generic/non-innovator products are coded differently, then the new NDCs for a non-innovator/generic drug shall be coded the same as the non-innovator/generic NDCs, and the new NDCs for brand/innovator products shall be coded the same as the innovator/brand NDCs.

5.3.2.8.4 Contractor shall report any discrepancies it identifies on the PDL file to the Department, in a format and manner prescribed by the Department, within three (3) Business Days of identification of the discrepancy.

5.3.2.9 **Attestation**. Contractor shall submit an attestation of its adherence to the Department's PDL for the first quarter of calendar year 2020, and quarterly thereafter, on a schedule and in a format provided by the Department.

5.3.2.10 **Compliance**. Compliance is the measure of preferred prescription drug utilization relative to all products in a class on the PDL. The Department will monitor Contractor's PDL compliance. Compliance will be measured as a count of preferred product claims paid by Contractor in a PDL class relative to the entirety of product claims paid by Contractor in that PDL class over a calendar quarter. Encounter claims data will be used for determining calendar quarter utilization. Encounters claims will be pulled sixty (60) days after the end of the quarter. PDL classes will be based upon class listings on the Department's PDL. When a product is listed with the brand preferred over its generic equivalent, the use of generic will count as non-preferred utilization.

5.3.2.11 **Grandfathering**. On January 1, 2020, for Enrollees prescribed non-preferred drugs that the Department has identified as grandfathered on the PDL, Contractor shall continue to cover that non-preferred drug. The initial grandfathering period shall be one (1) year, and the Enrollee shall be re-evaluated at the end of the one (1)-year period to determine whether grandfathering continues to be clinically appropriate for the Enrollee. Where the Department

prefers a brand over its generic equivalent in a class that is grandfathered, Contractor shall grandfather Enrollees on the brand product rather than the generic equivalent.

5.3.2.12 **Format of published formulary inclusive of the PDL.** Contractor's electronic and print formularies shall comply with the standardized format developed by the Department. Contractor shall adopt the Department's PDL categorization of drug classes and shall use the class names listed on the PDL. Contractor's published formulary shall contain, at minimum, the following:

5.3.2.12.1 brand and generic medications covered;

5.3.2.12.2 if medication is preferred or non-preferred and each term's definition;

5.3.2.12.3 each medication's tier and the definition of each tier;

5.3.2.12.4 utilization controls, including step therapy, prior approval, dosage limits, gender or age restrictions, quantity limits, and other policies;

5.3.2.12.5 cost sharing;

5.3.2.12.6 glossary of key terms and explanation of utilization controls and cost sharing;

5.3.2.12.7 a key for all utilization controls visible on every page in which specific medication coverage is displayed;

5.3.2.12.8 directions to obtain more information if a medication is not covered or listed in the formulary;

5.3.2.12.9 an e-mail and toll-free number to which an individual can report inaccuracies in the formulary; and

5.3.2.12.10 a disclosure that identifies the date of publication, a statement that the formulary is up to date as of publication, and contact information for questions and requests to receive updated information.

5.3.2.13 Contractor shall publish its formulary on its program website and make the formulary easily understandable and publicly accessible without a password, user name, or personality identifiable information.

5.3.2.14 Contractor shall provide printed formularies upon request.

5.3.2.15 Upon reports of formulary inaccuracies, Contractor must investigate and make correction to the data displayed. Data correction shall be completed within three (3) Business Days of notification of the error.

5.3.2.16 Contractor shall attest to the Department on a quarterly basis that it is making updates to the pharmacy formulary within three (3) Business Days after investigation of reported inaccuracies.

5.3.2.17 **340B drug billing**. Contractor shall ensure that it requires pharmacy, medical, and hospital Providers to identify 340B-purchased drugs on pharmacy, medical, and hospital claims following the Department billing guidelines applied in the FFS Medical Program. Contractor shall ensure that its Encounter claims to the Department also identify these drugs.

5.3.2.18 **Drug utilization reporting**. For outpatient drugs not identified in section 5.3.2.17, Contractor shall collect information on the total number of units of each dosage form, and strength, and package size by the National Drug Code of each covered outpatient drug dispensed to Enrollees. This requirement is considered met through the detail included on the pharmacy claims submitted to Contractor for pharmacy reimbursement.

5.3.2.19 Contractor shall report to the Department through pharmacy Encounter claims information on the total number of units of each dosage form, strength, and package size by the National Drug Code of each covered outpatient drug identified in section 5.3.2.18 dispensed to Enrollees.

5.3.2.20 **MAC price dispute resolution process**. Contractor shall establish and maintain a process for resolving disputes over generic drug maximum allowable costs (MAC), which is subject to approval by the Department. The MAC dispute-resolution process shall enable pharmacies to report pricing disputes to Contractor up to sixty (60) days from the claim and Contractor is required to resolve the pricing dispute within twenty-one (21) days after the report of the pricing dispute by adjusting the reimbursement rate to represent the acquisition cost of the drug, or by informing the pharmacy of alternative generic equivalent products that can be purchased at or below Contractor's existing MAC price.

5.3.2.21 **Drug Utilization Review (DUR)**. Contractor shall develop and implement a system of policies and procedures, coverage criteria, and processes for DUR program. The DUR program shall include a prospective review process for all drugs prior to dispensing, all non-formulary drug requests, and a retrospective DUR process to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse. Contractor is required to complete the Federal CMS MCO DUR annual report and return it to the Department for submission to CMS.

7. Section 5.4 is amended by deleting and replacing subsections 5.4.9 and 5.4.10, and is further amended by adding new subsection 5.4.11:

5.4.9 services or items furnished for the purpose of causing, or for the purpose of assisting in causing, the death of an Enrollee, such as assisted suicide, euthanasia, or mercy killing, except as otherwise permitted by P. L. 105-12, Section 3(b), which is incorporated by Section 1903(i)(l6) of the Social Security Act;

5.4.10 services for which Contractor uses any portion of a Capitation payment to fund roads, bridges, stadiums, or any other items or services that are not Covered Services.; and

5.4.11 effective November 1, 2019, abortion services.

8. Subsection 5.5.1 is deleted in its entirety and replaced with the following:

5.5.1 For the period January 1, 2018 through October 31, 2019, Contractor may provide termination of pregnancy only as allowed by applicable State and federal law. In any such case, Contractor shall fully comply with the requirements of such laws, complete HFS Form 2390, and file the completed form in the Enrollee's medical record. Contractor shall not provide termination of pregnancy to Enrollees who are eligible under SCHIP (215 ILCS 106).

9. Subsection 5.7.13 is deleted in its entirety and replaced with the following:

5.7.13 **Governmental Provider entities contracting requirement.** Contractor shall contract with the University of Illinois, Cook County, by and through its Cook County Health and Hospitals System, and Southern Illinois University (collectively, governmental Provider entities) in order to provide certain Covered Services to Enrollees if such governmental Provider entity is located within Contractor's Contracting Area set forth in Attachment II. Contractor shall reimburse the University of Illinois for inpatient hospital, outpatient hospital, Physician services, and encounter rate clinics at no less than their rates as determined by the Medicaid approved reimbursement methodologies, as provided to Contractor by the Department. Contractor shall reimburse Southern Illinois University for Physician services at no less than its rate as determined by the Medicaid-approved reimbursement methodologies, as provided to Contractor by the Department. For the period January 1, 2018 through December 31, 2019, Contractor shall reimburse Cook County for inpatient hospital, outpatient hospital, Physician services, and encounter rate clinics at no less than their rates as determined by the Medicaid approved reimbursement methodologies, as provided to Contractor by the Department. Contractor shall not limit equal access to such Providers.

10. Section 5.7 is amended by adding new subsection 5.7.15:

5.7.15 **Directed and Pass-through Payments.** Contractor shall comply with the Department's instructions in disbursing payments pursuant to CMS-approved directed payment programs and pass-through payments pursuant to 42 CFR 438.6. Directed payments must be made directly to an account of the Provider and cannot be made to an intermediary. The Department will transmit to Contractor detailed instructions on the distribution of funds at the time such funds are paid to Contractor. The instructions will indicate the amounts to be paid to each eligible Provider and the timeframe for making the payments.

11. Section 5.10 is amended by adding new subsection 5.10.13:

5.10.13 **IDoA HCBS Waiver Homecare Service Provider training**. Effective January 1, 2020, Contractor, upon request of a Homecare Service Provider, shall agree to allow Provider to certify compliance with Contractor's training requirements for Provider's personnel, when comparable training has been completed in accordance with requirements of 89 Ill. Admin. Code 240.1535. Contractor shall require Provider to utilize the Department's Attestation of Training Completion form and certify by individual employee.

12. Subsection 5.12.3.1 is deleted in its entirety and replaced with the following:

5.12.3.1 *Qualifications*. Care Coordinators who serve High-Needs Children, Special Needs Children, Enrollees within the IDoA Persons Who are Elderly HCBS Waiver, DHS-DRS Persons with a Brain Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, or DHS-DRS Persons with Disabilities HCBS Waiver must meet the applicable qualifications set forth in Attachment XVI. Care Coordinators for all other Enrollees must have the appropriate qualifications to address the needs of Enrollees.

13. Subsection 5.12.3.2 is deleted in its entirety and replaced with the following:

5.12.3.2 *Training requirements*. Care Coordinators who serve High-Needs Children, Special Needs Children, Enrollees within the IDoA Persons Who are Elderly HCBS Waiver, DHS-DRS Persons with a Brain Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, DHS-DRS Persons with Disabilities HCBS Waiver, or HFS Supportive Living Program HCBS Waiver must meet the applicable training requirements set forth in Attachment XVI. Care Coordinators for all other Enrollees must have the appropriate training to address the needs of Enrollees.

14. Subsection 5.13.1.4 is amended by deleting and replacing the subsection's table as follows:

Risk category	**Description**
Level 1: Low	Includes low- or no-risk Enrollees to whom Contractor provides, at a minimum, prevention and wellness messaging and condition-specific education materials.
Level 2: Moderate	Includes moderate-risk Enrollees for whom Contractor provides problem-solving interventions.
Level 3: High	Includes high-risk Enrollees for whom Contractor provides intensive Care Management for reasons such as addressing acute and chronic health needs, behavioral health needs, or addressing lack of social support.

15. Subsection 5.13.1.4.1 is amended by deleting and replacing the subsection's table as follows:

	Minimum percentages of Enrollees	
Population	**Level 2 and 3 (combined moderate- and high-risk)**	**Level 3 (high-risk)**
Families and Children Population	N/A	2%
ACA Adult population	N/A	2%
Special-Needs Children	40%	20%
Seniors or Persons with Disabilities	20%	5%
Dual-Eligible Adults	90%	20%

16. Subsection 5.13.2.1 is amended by deleting subsection 5.13.2.1.1:

5.13.2.1 All Enrollees stratified as Level 3 (high-risk) or Level 2 (moderate-risk). The assessment will be conducted, in-person or over the phone, within ninety (90) days after enrollment.

17. Section 5.18 is amended by adding new subsection 5.18.6:

5.18.6 Community Transitions Initiative

Effective January 1, 2020, Contractor shall implement an initiative specific to achieving transitions from institutional settings to the community for Enrollees who have continuously resided in a Nursing Facility or a Specialized Mental Health Rehabilitation Facility for a minimum of one-hundred twenty (120) days. Contractor shall prioritize community transitions for class members of the *Williams v. Quinn* and *Colbert v. Quinn* consent decrees. The initiative shall be in effect for each calendar year through 2021.

18. Subsection 5.19.1.1 is amended by adding new subsection 5.19.1.1.1:

5.19.1.1.1 Effective upon the implementation date of the HealthChoice Illinois – Children with Special Needs 1915(b) Waiver, the provisions of Section 5.19.1.1 apply for Special Needs Children Enrollees, with the exception that the transition period must be no less than one-hundred eighty (180) days.

19. Subsection 5.29.11.3 is deleted in its entirety and replaced with the following, and is further amended by adding new subsection 5.29.11.3.1:

5.29.11.3 Contractor shall complete retroactive adjustments for up to twenty-four (24) months to Nursing Facilities, and Supportive Living Facilities, and Specialized Mental Health Rehabilitation Facilities to account for patient credit liability amount changes.

5.29.11.3.1 Contract shall pay claims and retroactive adjustments beyond twenty-four (24) months to Nursing Facilities, Supportive Living Facilities, and Specialized Mental Health Rehabilitation Facilities in cases due to delays in the State's eligibility processing of long-term care admissions and income changes that prevented Contractor from processing a payment or adjustment.

20. Section 7.4 is amended by deleting and replacing subsections 7.4.1 and 7.4.3:

7.4.1 Capitation rates under this Contract, excluding the portion attributable to supplemental payments and other fees not retained by the MCOs, will be risk-adjusted by each population category against the other full-risk MCOs providing Covered Services to the same population category within the same rate-setting region. The population categories that will be risk-adjusted are adults and Children eligible under Title XIX and Title XXI; Affordable Care Act expansion–eligible adults; Medicaid-eligible older adults; adults with disabilities who are not eligible for Medicare; Dual-Eligible Adults receiving LTSS, excluding those receiving partial benefits or enrolled in the Illinois Medicare-Medicaid Alignment Initiative (MMAI); and Special-Needs Children, excluding Children in the care of DCFS. Beneficiaries under the age of two (2) will not be risk-adjusted. Capitation rates calculated under this Contract will be adjusted in accordance with publicly available risk-adjustment software. For calendar years prior to

2020, risk adjustment will be performed on a semiannual basis. Effective with the calendar year 2020 rating period, capitation rates will be risk adjusted at least annually. For an Enrollee's individual claims data to be the basis for a risk adjustment score hereunder, such Enrollee must have been enrolled in the HFS Medical Program (i.e., either managed care or Fee-For-Service) for at least six (6) full months during the time period from which claims data are used to calculate the adjustment. In the event an Enrollee has not been enrolled in the HFS Medical Program for at least six (6) full months, then such Enrollee shall receive a risk score equal to Contractor's average risk score. The risk scores shall be established for each MCO across all rate cells. As necessary, the risk scores will be established using a credibility formula for each MCO. The credibility formula to be used will be determined by an independent actuary. All diagnosis codes submitted by Contractor shall be included in calculations of risk scoring irrespective of placement of such diagnosis codes in the Encounter Data records. Diagnosis codes from claims or encounters that included a lab and radiology procedure or revenue code on any line, with the exception of those associated with an inpatient hospital claim, will not be collected for the risk-adjustment analysis. It is assumed that these diagnosis codes could be for testing purposes and may not definitively indicate a beneficiary's disease condition. Encounter records may not be supplemented by medical record data. Diagnosis codes may only be recorded by the Provider at the time of the creation of the medical record and may not be retroactively adjusted except to correct errors. A significant change in risk scores by a MCO may warrant an audit of the diagnosis collection and submission methods. To the extent that the Department's contracted actuarial firm believes Encounter Data limitations are resulting in risk score variances between MCOs, the Department reserves the right to request diagnosis codes and other information to perform risk adjustment.

7.4.3 For every six (6)–month period thereafter through calendar year 2019, Enrollee risk scores shall be recalculated using Enrollee claims or Encounter Data, as applicable, from a prior twelve (12)–month period. Effective with the calendar year 2020 rating period, capitation rates will be risk adjusted at least annually. The Department shall provide written notification to Contractor of Contractor's risk adjustment factor, along with sufficient detail supporting the calculations. Contractor shall have thirty (30) days after the date the Department sent such notice to review the calculations and detail provided and to submit questions, if any, to the Department regarding the same. No modification to Contractor's Capitation payment may be made during such thirty (30)–day review period. If during the review period Contractor disputes the risk adjustment factor, the Department shall agree to meet with Contractor within a reasonable timeframe to achieve a good faith resolution of the disputed matter. Modifications to Contractor's Capitation payment resulting from the application of the applicable risk adjustment factor, if any, shall be effective for the duration of the applicable adjustment period, effective as of the first day thereof. All risk scores shall be budget-neutral to the Department or normalized to a 1.0000 value between the MCOs.

21. Article VII is amended by adding new section 7.22:

7.22 **Maternity risk pool**. Pursuant to the retrospective maternity risk pool described in the applicable calendar year HealthChoice Illinois rate certification, Contractor shall participate in the risk pool arrangement on a calendar year basis. The risk pool is applicable to the non-disabled children and adults and Affordable Care Act Adult populations. Maternity services benefit costs and related non-benefit costs will be calculated for applicable rate cells by region. The aggregate amount of the risk pool will be determined by actual Enrollee months in the applicable rate cells and documented per Enrollee per month maternity-related expenses included in the respective rate cells. Risk pool amounts will be distributed based on maternal deliveries by Enrollees as documented by MCO-

submitted inpatient maternity admission Encounter Data through six (6) months following the end of the given calendar year. The Department will distribute funds among the MCOs by region and population. The distribution of funds will be budget-neutral to the Department for each calendar year. The Department will provide Contractor written notice of the risk pool results that contains sufficient documentation to support the calculations. Contractor shall have thirty (30) days to review the written notice and to submit questions, if any, to the Department. In the event Contractor disputes the risk pool results within the thirty (30) day review period, the Department will meet with Contractor within a reasonable time frame to achieve a good-faith resolution of the disputed matter.

22. Article VII is amended by adding new section 7.23 and its subsections:

7.23 Community Transitions Initiative Incentive Arrangement

The Department shall make incentive payments to Contractor, in accordance with 42 CFR 438.6, for achieving performance targets established for the Community Transitions Initiative discussed in section 5.18.6.

7.23.1 For Enrollees identified to transition from an institutional setting to the community, Contractor shall complete a comprehensive transition plan that includes evidence of appropriate permanent housing and submit to the Department for Prior Approval before transitioning an Enrollee to the community. To be considered a successful community transition Contractor must document in a format determined by the Department: (1) that the Enrollee continuously resides in the community setting for a minimum of six (6) months, and (2) the activities Contractor directly undertook to be primarily responsible for the Enrollee's community transition.

7.23.2 For Enrollees residing in an institution identified by Contractor as having an impairment, cognitive and/or medical, so significant that community transition is not a safe and viable option, Contractor shall document the basis for that determination in a completed comprehensive community transition evaluation and submit to the Department for Prior Approval.

7.23.3 The Department will determine minimum performance targets for: (1) successful community transitions, and, (2) Department-approved comprehensive community transition evaluations documenting impairments that preclude transition. Contractor must achieve the performance target(s) to qualify for an incentive payment. For each calendar year, incentive payment performance targets will be specified in a counter-signed letter between the Department and Contractor.

7.23.4 When Contractor achieves the specified performance target for successful community transitions, the Department will make an incentive payment of $4,000.00 for each transition. When Contractor achieves the specified performance target for Department-approved comprehensive community transition evaluations documenting impairments that preclude transition, the Department will make an incentive payment of $500.00 for each approved evaluation. For subsequent successful transitions and approved evaluations, incentive payments will be paid as they are achieved.

7.23.4.1 The Department will pay Contractor an additional incentive payment of $500.00 upon an Enrollee's community transition date anniversary when the Enrollee has continued to reside in the community. Contractor may earn this incentive payment, for each transitioned Enrollee, up to a maximum of three such annual payments.

23. *Attachment I: Service Package II Covered Services and MLTSS Covered Services* is amended by deleting the *MLTSS Covered Services* table and replacing with the attached *MLTSS Covered Services* table.

24. *Attachment XVI: Qualifications and Training Requirements of Certain Care Coordinators and Other Care Professionals* is amended by deleting and replacing subsection 1.1.5 as follows:

1.1.5 High-Needs and Special Needs Children.

25. *Attachment XVI: Qualifications and Training Requirements of Certain Care Coordinators and Other Care Professionals* is further amended by deleting subsection 1.3.1.5 in its entirety and replacing with the following:

1.3.2 **High-Needs and Special Needs Children.**

1.3.2.1 All Care Coordinators must attend the Introduction to Wraparound and Engagement trainings offered by an NWIC-certified trainer and any follow-up training modules developed and made available by the State.

1.3.2.2 All Supervisors overseeing Care Coordinators assigned to Intensive/Intervention tier Enrollees must be certified as Wraparound coaches by a State-identified and approved entity.

26. The Contract is amended by adding a new attachment – *Attachment XXIV: Requirements Specific to DCFS Youth in Care Enrollees*, attached herein.

IN WITNESS WHEREOF, the Parties have hereunto caused this Amendment No. 5 to the Contract to be executed by their duly authorized representatives, effective as of the date of last signature.

[MANAGED CARE ORGANIZATION]

By:_____

Printed Name:_____

Title:_____

Date:_____

FEIN:_____

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

By:_____

Printed Name:_____

Title:_____

Date:_____

MLTSS Covered Services

Category of service	Definition	MLTSS coverage
001	Physician Services	EXCLUDED
002	Dental Services	EXCLUDED
003	Optometric Services	EXCLUDED
004	Podiatric Services	EXCLUDED
005	Chiropractic Services	EXCLUDED
006	Physicians Psychiatric Services	EXCLUDED
007	Development Therapy, Orientation and Mobility Services (Waivers)	EXCLUDED
008	DSCC Counseling/Fragile Children	EXCLUDED
009	DCFS Rehab Option Services	EXCLUDED
010	Nursing service	EXCLUDED
011	Physical Therapy Services	EXCLUDED
012	Occupational Therapy Services	EXCLUDED
013	Speech Therapy/Pathology Services	EXCLUDED
014	Audiology Services	EXCLUDED
015	Sitter Services	EXCLUDED
016	Home Health Aides	EXCLUDED
017	Anesthesia Services	EXCLUDED
018	Midwife Services	EXCLUDED
019	Genetic Counseling	EXCLUDED
020	Inpatient Hospital Services (General)	EXCLUDED
021	Inpatient Hospital Services (Psychiatric)	EXCLUDED
022	Inpatient Hospital Services (Physical Rehabilitation)	EXCLUDED
023	Inpatient Hospital Services (ESRD)	EXCLUDED
024	Outpatient Services (General)	EXCLUDED
025	Outpatient Services (ESRD)	EXCLUDED
026	General Clinic Services	EXCLUDED
027	Psychiatric Clinic Services (Type 'A')	EXCLUDED
028	Psychiatric Clinic Services (Type 'B')	EXCLUDED
029	Clinic Services (Physical Rehabilitation)	EXCLUDED
030	Healthy Kids Services	EXCLUDED
031	Early Intervention Services	EXCLUDED
032	Environmental modifications (waiver)	EXCLUDED
033	Mental Health Clinic Option Services	EXCLUDED
034	Mental Health Rehab Option Services	COVERED SERVICE
035	Alcohol and Substance Abuse Rehab. Services	COVERED SERVICE
036	Juvenile Rehabilitation	EXCLUDED

037	Skilled Care - Hospital Residing	EXCLUDED
038	Exceptional Care	COVERED SERVICE
039	DD/MI Non-Acute Care - Hospital Residing	EXCLUDED
040	Pharmacy Services (Drug and OTC)	EXCLUDED
041	Medical equipment/prosthetic devices	EXCLUDED
042	Family planning service	EXCLUDED
043	Clinical Laboratory Services	EXCLUDED
044	Portable X-Ray Services	EXCLUDED
045	Optical Supplies	EXCLUDED
046	Psychiatric Drugs	EXCLUDED
047	Targeted case management service (mental health)	COVERED SERVICE
048	Medical Supplies	EXCLUDED
049	DCFS Targeted Case Management Services	EXCLUDED
050	Emergency Ambulance Transportation	EXCLUDED
051	Non-Emergency Ambulance Transportation	COVERED SERVICE
052	Medicar Transportation	COVERED SERVICE
053	Taxicab Services	COVERED SERVICE
054	Service Car	COVERED SERVICE
055	Auto transportation (private)	COVERED SERVICE
056	Other Transportation	COVERED SERVICE
057	Nurse Practitioners Services	EXCLUDED
058	Social work service	COVERED SERVICE
059	Psychologist service	COVERED SERVICE
060	Home Care	EXCLUDED
061	General Inpatient	EXCLUDED
062	Continuous Care Nursing	EXCLUDED
063	Respite Care	EXCLUDED
064	Other Behavioral Health Services	COVERED SERVICE
065	LTC Full Medicare Coverage	EXCLUDED
066	Home Health Services	EXCLUDED
067	All Kids application agent (valid on provider file only)	EXCLUDED
068	Targeted case management service (early intervention)	EXCLUDED
069	Subacute Care Program	EXCLUDED
070	LTC - Skilled	COVERED SERVICE
071	LTC - Intermediate	COVERED SERVICE
072	LTC--NF skilled (partial Medicare coverage)	EXCLUDED
073	LTC--ICF/MR	EXCLUDED
074	LTC--ICF/MR skilled pediatric	EXCLUDED
075	LTC - MI Recipient age 21-64	COVERED SERVICE
076	LTC - Specialized Living Center - Intermediate MR	EXCLUDED
077	SOPF--MI recipient over 64 years of age	COVERED SERVICE
078	SOPF--MI recipient under 22 years of age	COVERED SERVICE

079	SOPF--MI recipient non-matchable	COVERED SERVICE
080	Rehabilitation option service (special LEA service)	EXCLUDED
081	Capitation Services	EXCLUDED
082	LTC--Developmental training (level I)	EXCLUDED
083	LTC--Developmental training (level II)	EXCLUDED
084	LTC--Developmental training (level III)	EXCLUDED
085	LTC - Recipient 22-64 in IMD not MI or MR	COVERED SERVICE
086	LTC SLF Dementia Care	COVERED SERVICE
087	LTC - Supportive Living Facility (Waivers)	COVERED SERVICE
088	Licensed Clinical Professional Counselor (LCPC)	COVERED SERVICE
089	LTC - MR Recipient - Inappropriately Placed	EXCLUDED
090	Case Management	EXCLUDED
091	Homemaker	COVERED SERVICE
092	Agency Providers RN, LPN, CNA and Therapies	COVERED SERVICE
093	Individual Providers PA, RN, LPN, CNA and Therapies	COVERED SERVICE
094	Adult Day Health	COVERED SERVICE
095	Habilitation Services	COVERED SERVICE
096	Respite Care	COVERED SERVICE
097	Other HCFA Approved Services	COVERED SERVICE
098	Electronic Home Response/EHR Installation (MARS), MPE Certification (Provider), Automated Medication Dispenser	COVERED SERVICE
099	Transplants	EXCLUDED
100	Genetic counseling	EXCLUDED
102	Fluoride varnish	EXCLUDED

ATTACHMENT XXIV: REQUIREMENTS SPECIFIC TO DCFS YOUTH IN CARE ENROLLEES

1.1 DEFINITIONS

1.1.1 **Authorized Representative** means an individual, case worker, group, entity, or other person(s) approved by DCFS Guardianship Administrator who is legally authorized to speak for or on behalf of the Enrollee and which has been communicated to Contractor through DCFS.

1.1.2 **Comprehensive Health Evaluation** means the evaluation that is conducted within twenty-one (21) days of DCFS temporary custody and includes: (i) an Early and Periodic Screening, Diagnostic and Treatment program (EPSDT) examination; (ii) vision, hearing, and dental screening, when appropriate; and (iii) mental health, developmental, and alcohol and substance abuse screenings, when appropriate. Resulting referrals for specialized services are made as needed.

1.1.3 **DCFS** means the Illinois Department of Children and Family Services.

1.1.4 **DCFS Authorized Agent** means DCFS staff who have been appointed and authorized by the DCFS Guardianship Administrator to officially act in the place of the DCFS Guardianship Administrator to authorize and consent to matters concerning DCFS Youth in Care.

1.1.5 **DCFS Caseworker** means the representative of record who has primary responsibility for a DCFS Youth in Care's child welfare case management, working with the youth and the youth's family to identify services to address issues that brought the youth into the child welfare system and providing updates to and making court appearances in the youth's Juvenile Court case. The DCFS Caseworker may be employed by DCFS or by a contracted Purchase of Service (POS) agency and may also be referred to as a "permanency worker."

1.1.6 **DCFS Guardianship Administrator** means that person designated by the Director of DCFS to serve as guardian of children accepted by DCFS pursuant to the Juvenile Court Act, the Children and Family Services Act, the Abused and Neglected Child Reporting Act, and the Adoption Act. The DCFS Guardianship Administrator has the legal authority to consent to certain medical and behavioral health services for DCFS Youth in Care based on the specific orders entered in the Juvenile Court and on the specific ages of DCFS Youth in Care, in accordance with DCFS Rule 327.

1.1.7 **DCFS Service Plan** means a written plan on a form prescribed by DCFS that guides all individuals in the plan of child welfare intervention toward the permanency goals for DCFS Youth in Care. The DCFS Service Plan is developed by the DCFS Caseworker and other members of the Child and Family Team in accordance with DCFS Procedure 302, and indicates all services required for the child including services that are ordered by Juvenile Court.

1.1.8 **DCFS Youth** means both DCFS Youth in Care and Former Youth in Care who are Potential Enrollees, Prospective Enrollees or Enrollees.

1.1.9 **DCFS Youth in Care** means a youth who is under the legal custody or guardianship of DCFS.

1.1.10 **Former Youth in Care** means a youth under the age of 21 who was previously under the legal custody or guardianship of DCFS but was reunified with their biological family, was adopted, was placed in subsidized guardianship, or whose Juvenile Court case was closed and is no longer under the legal custody of DCFS.

1.1.11 **Health Passport** means a summary of health information for each DCFS Youth in Care that contains the youth's health history, present health care and medical conditions, if any, and available health information about the youth necessary for the youth's proper care.

1.1.12 **HealthWorks** means a comprehensive system of health care developed by DCFS for all Illinois children and youth in foster care that ensures they have access to quality health care, routine health care and special health care that meets their identified health care needs and provides documentation of health needs and health care information that is readily accessible to caregivers, other healthcare providers and DCFS. HealthWorks provides access to and referral for primary health care physicians, initial health screenings, comprehensive health evaluations, well-child examinations and immunizations.

1.1.13 **Initial Health Screening** means the medical screening that is conducted within twenty-four (24) hours of DCFS temporary custody to identify health conditions that require prompt medical attention and to consider in making substitute care placement decisions.

1.1.14 **Interim Medical Case Management** means medical case management services provided by a HealthWorks lead agency for a child within the first forty-five (45) days of being placed in DCFS temporary custody. Activities required include, at a minimum, enrollment in HealthWorks, selection of a primary care physician, gathering of child and family health information, initiation of requests for prior health records, receipt of initial health screening documentation, completion of a Comprehensive Health Evaluation, ensuring provision of the Health Passport to the caregiver of the child, providing appropriate documentation and other information to the assigned permanency worker for inclusion in the DCFS Service Plan, and supporting the completion of any appropriate screening tools as necessary.

1.1.15 **Juvenile Court** means a court that is presiding over matters related to petitions alleging that a child or youth is abused, neglected, dependent or delinquent under the provisions of the Juvenile Court Act, 705 ILCS 405.1 et seq.

1.1.16 **Permanency Goal** means the desired outcome of child welfare intervention and service that is determined to be consistent with the health, safety, well-being, and best interests of the DCFS Youth in Care as defined by the Juvenile Court Act.

1.1.17 **Psychotropic Medication** means any medication capable of affecting the mind, emotions and behavior. This includes medications whose use for antipsychotic,

antidepressant, antimanic, antianxiety, behavioral modification or behavioral management purposes is listed in AMA Drug Evaluations, latest edition, or Physician's Desk Reference, latest edition or that are administered for any of these purposes [405 ILCS 5/1-121.1]. For the purpose of this definition, medications used to induce or sustain sleep or to treat symptoms of aggression, enuresis and psychotropic medication-induced adverse effects are also included.

1.1.18 **Purchase of Service (POS) Agency** means a licensed child welfare agency with whom DCFS contracts to provide child welfare services to youth and families.

1.1.19 **Retained Behavioral Health Services** means all behavioral health services which are potentially eligible for reimbursement under Medicaid but are being paid by DCFS, as of the Comprehensive Implementation Date.

1.1.20 **Significant Events** are serious, sometimes traumatic occurrences that affect children and youth served by DCFS, are subject to mandatory reporting requirements, and are described in additional detail in DCFS Procedure 331.

1.2 TRANSITION FROM YOUTH IN CARE TO FORMER YOUTH IN CARE

1.2.1 At the time a DCFS Youth in Care Enrollee becomes a Former Youth in Care, the Enrollee will remain enrolled with Contractor until the Enrollee's next Open Enrollment Period.

1.3 WELCOME PACKET

1.3.1 Within five (5) Business Days of receipt of the 834 Daily file from the Department confirming that an enrollment was accepted, Contractor shall send an Enrollee welcome packet to the individual(s) designated by the State.

1.4 PHARMACY REQUIREMENT

1.4.1 Contractor shall comply with the requirements of DCFS Rule and Procedure 325, including all requirements for consents and the development of a system that maintains the requirement of prior authorization from DCFS prior to the administration of any psychotropic medication and stops prescriptions for psychotropic medications from being filled at a pharmacy if no prior authorization has been received from DCFS.

1.5 INTEGRATED HEALTH HOMES EXPERIENCE

1.5.1 Contractor shall ensure that IHHs serving DCFS Youth in Care have previous experience coordinating services for Special Needs Children.

1.6 INTERIM MEDICAL CASE MANAGEMENT CONTRACTING REQUIREMENT

1.6.1 Contractor is responsible for the provision of Interim Medical Case Management. In the event a DCFS Youth in Care, upon enrollment with Contractor, is receiving services

through a HealthWorks lead agency, Contractor shall enter into a single-case agreement with that HealthWorks lead agency to provide Interim Medical Case Management through the first forty-five (45) days of DCFS custody of the youth. The Interim Medical Case Management services shall include, at a minimum, gathering of child and family health information, initiation of requests for prior health records, receipt of twenty-four (24) hour initial health screenings, selection of primary care physician, completion of the Comprehensive Health Evaluation within twenty-one (21) days of DCFS temporary custody and provision of the Health Passport to the DCFS Youth in Care's caregivers, and supporting the completion of any appropriate screening tools as necessary.

1.7 COORDINATION AND COMMUNICATION TOOLS

1.7.1 Contractor shall have fully operational portals, and secure email, which provide the DCFS Guardianship Administrator or Authorized Agents, DCFS Caseworkers, Enrollees, and Providers access to relevant information from the Care Management system, as applicable.

1.8 RISK STRATIFICATION

1.8.1 In the event DCFS is not in agreement with the risk level determination made by Contractor for a DCFS Youth in Care Enrollee, Contractor will work collaboratively with the Department and DCFS to resolve the disagreement and ensure that the best interest and needs of the DCFS Youth in Care Enrollee are met.

1.9 INTERDISCIPLINARY CARE TEAM (ICT)

1.9.1 Contractor shall support an ICT for all DCFS Youth in Care Enrollees stratified as Level 3 (high-risk) and Level 2 (moderate-risk). Contractor shall make reasonable efforts to collaborate with the DCFS Caseworker to ensure that the ICT is coordinated with all DCFS team-based decision-making processes, such as Child and Family Team meetings; that the Care Coordinator is able to participate, as needed, in the DCFS team-based decision-making process; and, that the IPoC is updated as necessary with information or decisions made during a DCFS team-based decision-making process.

1.10 INDIVIDUALIZED PLANS OF CARE (IPOC) AND SERVICE PLANS

1.10.1 Contractor shall develop an IPoC for all DCFS Youth in Care Enrollees stratified as Level 3 (high-risk) and Level 2 (moderate-risk). Contractor shall include information from DCFS as available. The IPoC shall be coordinated and consistent with the DCFS Service Plan as follows, given that DCFS provides this information to Contractor:

1.10.1.1 The IPOC shall include all goals and services that are necessary to support the Permanency Goal established in the DCFS Service Plan, given that DCFS provides this information to Contractor.

1.10.1.2 Information from the DCFS Service Plan will be incorporated into the IPoC as available.

1.10.1.3 Contractor shall not have responsibility for the payment for any non-Medicaid Services included in the DCFS Service Plan. DCFS shall retain responsibility for payment for all non-Medicaid Services.

1.10.1.4 Contractor shall notify the DCFS Caseworker within two (2) Business Days when the IPoC is updated. The updated IPoC shall be available for the DCFS Caseworker through the Enrollee portal.

1.11 APPROVED CONTACTS FOR DCFS YOUTH IN CARE ENROLLEES

1.11.1 Contractor shall ensure that contact is made only with Authorized Representatives.

1.12 HEALTH, SAFETY, AND WELFARE MONITORING

1.12.1 Contractor shall comply with DCFS rules and procedures for reporting Significant Events.

1.13 ADDITIONAL TRAINING FOR CARE COORDINATORS

1.13.1 Contractor's Care Coordinators assigned to DCFS Youth in Care Enrollees shall be familiar with DCFS-required assessments for DCFS Youth in Care and the DCFS team-based decision- making process. Contractor shall train Care Coordinators in various aspects of the Illinois child welfare system to include trauma informed care, the psychotropic consent process, Illinois Medicaid Child and Adolescent Needs and Strengths (IM-CANS), motivational interviewing, and other relevant information that receives the Department's Prior Approval. Contractor shall have no less than two (2) Care Coordinators who have attended the Department-sponsored DCFS managed care and child welfare training.